

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2016	
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of Complaints IN00190558, IN00190612 and IN00190668.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00190558 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00190612 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00190668 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 10, 11, 12, 13, 14, and 15, 2016..</p> <p>Facility number: 012225 Provider number: 155780 AIM number: 200983560</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 10 Medicaid: 62 Other: 12 Total: 84</p> <p>Sample: 05</p> <p>Madison Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2.3.1 in regard to the Investigation of</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2016
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 Complaints IN00190558, IN00190612, and IN00190668. Quality review completed by 14466 on January 25, 2016.	F 000			